SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS
Request for Supervised Living Support

Region _____ **( ) Start Up Payment (SLP I only)***

County _____ **( ) Monthly Payment**

( ) One-Time Payment

Provider Agency ___

Individual _____ **Date of Birth** .

Individual's Social Security Number (if available**):** _____

or DDSN CIS "T" Number: T- __

Medicaid # (if applicable) _

Parent(s)/Guardian(s) ____
(if applicable)

Address ____

____

Telephone __

Individual Information:

Level of retardation:

Present program attending:

Present Living Accommodations: _____

Trailer _____ **Apartment** __
House . **Other** .

Present Medical Status ____

_____

Amount Requested: .

***Only SLP I individuals are eligible for placement assistance. Placement assistance for SLP II, CTH I and CTH II's are now included in each of the provider contracts**

for those programs.

Request for Supervised Living Support
Page 2

Purpose of Request:

_____

_____

_____

_____

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_____

Service Coordinator's Recommendations: (include alternatives considered**)**

_____

_____

_____

_____

_____

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_____

NOTE: Attach copy of current Plan of Service identifying type of services presently being received. Attach additional client information, inclusive of current Social Assessment.

_____ _____
Service Coordinator Signature **Date**

CL# _

_____ _____
Director, Service Coordination Signature **Date**

Revised 8/28/95

Request for Supervised Living Support
Page 3

SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS
Regional Office Review

Applicant's Name __ **Date Processed ____**

DIRECTOR OF SERVICE COORDINATION

Approved ___ Not Approved _____

Amount Approved _ **Service _____**

Approval Period ___ **Review Date _**

Comments: _

_____

_____

_____ **_____**

Director of Service Coordination **Date**

DIRECTOR OF SUPPORTS

Approved ___ Not Approved _____

Amount Approved _ **Date Approved ____**

Comments: _

_____

_____ **_____**

Regional office Administrator **Date**

REGIONAL DIRECTOR

Approved ___ Not Approved _____

Amount Approved _ **Date Approved ____**

Comments: _

_____

_____ _____

Regional Director **Date**

Request for Supervised Living Support
Page 4

CENTRAL OFFICE APPROVAL
For Request Above Allowable Limits

Date Received _____

We have reviewed your request for financial support above the allowable limits and

Concur _____ **Do Not Concur** _

Comments: _

_____

_____

_____

_____

_____ _____

Assistant Deputy Director Family Support

Deputy Director for Services & Programs

Revised 8/28/95